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	175338	A. BUILDING _____ B. WING _____	01/23/2014

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BALDWIN HEALTHCARE & REHAB CTR	1223 ORCHARD LANE BALDWIN CITY, KS 66006

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS00070240, #KS00070781, and #KS00071103.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This Requirement is not met as evidenced by: The facility identified a census of 54 residents. The sample included 19 residents. Based on observation, interview, and record review the facility failed to develop comprehensive care plans to include sleep hygiene and Range of Motion (ROM) for 3 of 19 residents. (#46, #47, #65) Findings included:	F 279		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279	Continued From page 1 - Resident #47's annual Minimum Data Set 3.0 Assessment (MDS) dated 10-27-13, documented the resident's Brief Interview for Mental Status score was 15, which indicated the resident's cognition was intact. The resident required extensive assistance of staff with activities of daily living (ADLs) for bed mobility and dressing, and required total assistance of staff for transfers and toileting. The resident did not receive therapy, but received assistance of staff for placement of a splint 3 days a week. The ADL Care Area Assessment (CAA) dated 10-27-13, documented the resident had severe mobility impairment and was dependent on staff for most of his/her ADLs. The 12-9-13 care plan documented the resident had impaired mobility and multiple joint contractures (an abnormal permanent fixation of a joint). The resident required total assistance of staff for all ADLs, transfers, toileting, personal care, and repositioning. The care plan directed staff to perform passive Range of Motion (ROM) to the affected joints, teach the resident to perform active ROM to his/her affected joints and exercise as ordered by the physician. The care plan documented the resident had arthritis (painful inflammation and stiffness of the joints), was at risk for decreased joint mobility, had splints to his/her hands and directed staff to encourage the resident to wear the splints, as he/she refused often. Record review of the December and January 2014 Restorative Nursing Record documented staff applied a ring splint to the resident's right hand and a splint to the left hand in the afternoon seven days per week. On 1-13-14 the	F 279		

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Restorative Nursing Record documented staff soaked the resident's right hand after lunch and Occupational Therapy provided splint therapy for the resident. The Restorative Nursing Record documented the resident refused the hand soaks daily.

Observation on 1-16-14 at 8:05 A.M. revealed the resident as he/she sat in his/her wheelchair in the dining room. All the resident's fingers were contracted and contorted. The resident ate his/her meal independently.

On 1-21-14 at 11:07 A.M. direct care staff P stated the resident had ring splints and the resident was able to put them on and take them off him/herself. He/she stated he/she was not involved with placing the splints on the resident.

On 1-21-14 at 1:53 P.M. direct care staff W stated he/she soaked the resident's hand and performed passive ROM on the resident's fingers while they soaked. He/she stated the splint therapy was discontinued and direct care staff placed splints on the resident's hands at night.

On 1-21-14 at 1:29 P.M. licensed staff H stated the restorative certified nursing assistant (CNA) soaked the resident's hands and provided ROM and staff no longer applied the ring splint to the resident's hand.

The undated facility provided Care Planning policy and procedure documented each resident's care plan was current, individualized and consistent with the MDS and Resident Assessment Protocol (RAP).

The facility failed to develop a comprehensive individualized care plan to include soaking and

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number of repetitions for ROM for the resident's hands daily.

- Resident #65's admission Minimum Data Set 3.0 Assessment (MDS) dated 12-24-13 documented the resident's Brief Interview for Mental Status score was 5, which indicated the resident had severe cognitive impairment. The resident required extensive assistance for activities of daily living (ADLs) for bed mobility, transfers, toileting, and personal hygiene. The resident required total assistance of staff for eating, and locomotion.

The Psychotropic Care Area Assessment (CAA) dated 12-17-13 documented the resident had behaviors in the past and continued to holler out at times.

The 12-27-13 Care Plan lacked documentation the resident received Trazodone (a medication used for depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), anxiety, (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and sleep).

The January 2014 Medication Administration Record (MAR) documented the resident received Trazodone 50 milligrams (mg) at bedtime for insomnia (inability to fall asleep). The MAR documented staff received the order on 12-17-13.

The January 2014 Behavior Monitoring sheet documented the resident received Trazodone for complaints of trouble sleeping.

The record lacked evidence staff provided sleep

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F 279	Continued From page 4 hygiene interventions prior to administering Trazodone to the resident. Observation on 1-21-14 at 9:50 A.M. revealed the resident sat in his/her recliner by his/her bed. The resident was not able to answer any questions appropriately. On 1-16-14 at 3:10 P.M. direct care staff O stated the resident was able to state his/her needs and staff were not aware the resident had difficulty falling asleep on his/her own. On 1-16-14 at 3:19 P.M. licensed nurse I stated staff offered the resident food, and tried to pacify him/her in other ways before giving the resident his/her medication. He/she stated the resident became anxious and the medication helped him/her sleep better. On 1-26-14 at 2:26 P.M. administrative nurse D stated he/she was unaware the resident took the medication for sleep, but instead for depression and acknowledged the care plan lacked interventions for sleep hygiene for the resident. The undated facility provided Care Planning policy and procedure documented each resident's care plan was current, individualized and consistent with the MDS. The facility failed to develop a comprehensive individualized care plan for sleep hygiene for this dependent resident who received Trazodone for insomnia. - Resident #46's quarterly Minimum Data Set (MDS) 3.0 dated 10/13/13 recorded the resident	F 279		

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F 279	Continued From page 5 with a Brief Interview for Mental Status not completed which indicated the resident had severe cognitive impairment. The MDS recorded the resident required extensive assistance with bed mobility, transfers, and total dependence with toilet use and personal hygiene. The care plan dated 1/14/14 documented for staff to provide a restorative program as needed. The care plan lacked the restorative program which included a physician's order on 8/19/13 to ambulate the resident down the hallway with a Broda chair following and stretching the residents leg muscles. Observation on 1/21/14 at 11:55 A.M. one staff member assisted the resident to stand and walk with the use of a walker down the hall. Interview with restorative aide W on 1/16/14 at 3:30 P.M. stated he/she spent time every day on strengthening the resident in walking. Interview with administrative licensed staff D on 1/21/14 at 10:02 A.M. stated the nurses do not typically write on the care plan. Staff D and another nurse updated the care plans every morning with new orders. Interview with licensed staff H on 1/21/14 at 11:13 A.M. stated restorative staff worked with the resident every day. The resident had improved since he/she was first admitted. The facility policy dated 9/18/08 documented a care plan was developed and updated to reflect restorative interventions. The facility failed to develop an individualized	F 279		

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F 279	Continued From page 6 comprehensive care plan for this dependant resident who received restorative therapy.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This Requirement is not met as evidenced by: The facility identified a census of 54 residents. The sample included 19 residents. Based on observation, interview, and record review the facility failed to review and revise the care plan for 1 residents of the sample (#11) Findings included: - Resident #11's quarterly Minimum Data Set 3.0 Assessment (MDS) dated 12-18-13 documented the resident's Brief Interview for Mental Status score was 14, which indicated the resident was	F 280		

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cognitively intact. The resident required extensive assistance of staff for activities of daily living (ADLs) that included bed mobility, locomotion, toileting, and personal hygiene. The resident was incontinent of bowel and bladder.

The 10-1-13 Incontinence Care Area Assessment (CAA) triggered but was not completed on the assessment.

The 11-26-13 care plan documented the resident was frequently incontinent at night and directed staff to initiate a scheduled toileting plan based upon his/her assessment. The care plan directed staff to assist the resident to the bathroom as needed. The care plan lacked individualized interventions regarding the resident's incontinence and toileting needs.

The 9-19-13 Assessment for Bowel and Bladder retraining documented the resident was incontinent at night and the total score for the assessment was 14, which indicated the resident was a candidate for scheduled toileting.

The 3 day Voiding Pattern dated 12-26-13 and 1-3-14 documented to stop monitoring the resident's voiding pattern and check and change the resident every 2 hours for incontinence.

Observation on 1-16-14 at 1:09 P.M. revealed direct care staff R and Q in the resident's room. Direct care staff Q placed a gait belt around the resident and assisted the resident from his/her wheelchair into his/her recliner. Direct care staff R felt the incontinence pad in the resident's wheelchair and stated the pad was wet and they needed to change the resident's clothing and take him/her to the bathroom. They positioned the resident in the wheelchair and assisted the

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resident to the toilet. Direct care staff Q removed the resident's brief and revealed unformed bowel on the brief. At this time direct care staff Q stated the brief was wet from a watery bowel movement. Both staff assisted the resident to a standing position and the resident used the grab bar to stand while direct care staff R cleansed the resident's buttocks. Direct care staff R wiped between the resident's legs from front to back one time. He/she did not cleanse the front perineal area. Both staff assisted with putting a clean brief and pants on the resident and sat the resident down in his/her wheelchair on the wet incontinence pad. Both staff placed the resident in his/her recliner, removed the soiled clothing, removed their gloves, and washed their hands.

On 1-16-14 at 1:30 P.M. direct care staff Q stated the resident often said he/she was not wet or did not need to use the bathroom, but would be wet or soiled with stool.

On 1-16-14 at 3:02 P.M. direct care staff R stated he/she toileted the resident every 2 hours.

On 1-21-14 at 11:07 A.M. direct care staff P stated he/she toileted the resident frequently throughout the day. He/she stated the resident alerted staff at times if he/she needed to go to the bathroom and often had loose watery stools.

On 1-21-14 at 1:29 P.M. licensed nurse H stated staff checked the resident every 2 hours and the resident was able to state his/her toileting needs also, but when he/she needed to go to the bathroom, it had to be immediate, otherwise the resident was incontinent.

On 1-26-14 at 2:26 P.M. administrative nurse D stated the staff should have updated the

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F 280	Continued From page 9 resident's care plan to address his/her change in incontinence status and the resident was incontinent of bowel and bladder. The undated facility provided Care Planning policy and procedure documented each resident's care plan was current, individualized and consistent with the MDS. The facility failed to review and revise the care plan to address the resident's change in his/her toileting needs and decline in his/her incontinence status.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This Requirement is not met as evidenced by: The facility identified a census of 54 residents. The sample included 19 residents. Based on interview and record review the facility failed to develop an individualized care plan to sufficiently meet the needs for two residents that included a newly inserted percutaneous endoscopic gastric tube (PEG, a tube surgically inserted into the stomach for nourishment) and hydration. (#73, #20) Findings included: - Resident #73's significant change Minimum Data Set 3.0 Assessment (MDS) dated 10-27-13 documented the resident's short and long term memory intact. The resident required extensive assistance with activities of daily living (ADLs), received hospice services, had PEG tube placement and was dehydrated.	F 281		

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F 281	Continued From page 10 The Feeding Tube Care Area Assessment (CAA) dated 10-27-13, documented the resident had a PEG tube placed while in the hospital, spent most of his/her time in bed, attempted to remove the tube, often refused oral intake, and received his/her nutrition from the PEG tube. The 10-21-13 temporary care plan documented the resident had a PEG tube and attempted to remove it him/herself, so staff wrapped the tube to prevent the resident from pulling it out. The care plan lacked any further interventions that directed staff on care for the resident with the PEG tube. The 11-1-13 care plan documented the resident received his/her nutrition from a PEG tube and refused to eat. Interventions directed staff to monitor the resident's dietary intake, received Jevity (a high protein, high calorie nutritional supplement) 4 cans daily and staff flushed the tube with 60 cubic centimeters (cc) of water before and after feedings and if the resident refused the feedings, respect his/her wishes. The care plan lacked interventions for care regarding the PEG tube. The 10-23-13 Physician's progress note documented the resident had a very poor prognosis, had probable anal cancer with metastasis (A term for diseases in which abnormal cells divide without control and can invade nearby tissues), had a 10 pound weight loss, received hospice services and life expectancy was a few weeks. On 10-21-13 at 9:11 P.M. the nurse's note (NN) documented the resident returned to the facility by ambulance and had a PEG tub in place.	F 281		

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F 281	Continued From page 11 On 10-28-13 at 8:30 A.M. the NN documented the resident refused to eat his/her meals and allowed staff to provide nourishment through his/her tube feeding. According the the clinical record, the resident expired on 11-4-13. On 1-16-14 at 2:47 P.M. licensed nursing staff J stated the resident admitted to the facility on hospice services. The resident had a lot of pain in his/her anal area due to a large open anal growth. He/she stated the resident often refused pain medication, often refused to eat or drink and was dehydrated. He/she stated the family decided to pursue more aggressive treatment, and took the resident to the hospital. Licensed nursing staff J stated the resident returned to the facility several weeks later with a PEG tube in place. On 1-21-14 at 8:58 A.M. administrative licensed nurse D stated the resident had a poor prognosis, often refused to eat, and received nourishment through his/her PEG tube. After reviewing the care plan, he/she stated the comprehensive care plan was not on the chart and was in the computer since the resident expired before the comprehensive care plan was completed. On 1-21-14 at 10:00 A.M. administrative licensed nurse D stated he/she would not expect the PEG tube to be on the care plan until the comprehensive care plan was completed. He/she stated when the resident went to the hospital and came back, he/she considered the resident as a new admission. He/she stated he/she would not expect the PEG tube interventions to be on the temporary care plan	F 281		

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F 281	Continued From page 12 unless staff received new orders after admission for the PEG tube. The undated facility provided Care Planning policy and procedure documented each resident's care plan was current, individualized and consistent with the MDS. The facility failed to develop a temporary care plan to sufficiently meet the needs for this newly admitted resident with a newly placed PEG tube. - Resident #20's (closed record) December 2013 physician's order sheet (POS) recorded the resident admitted on 12/9/13 with diagnosis of dehydration (fluid removal from a substance, fluid intakes that fail to match fluid losses). The 5 day admission Minimum Data Set (MDS) 3.0 assessment dated 12/13/13 documented the resident with short and long term memory impairment and severe cognitive impairment. The MDS recorded the resident required extensive assistance of one staff member with bed mobility, transfers, dressing, toilet use, and total assistance of one staff member with locomotion on the unit and limited assistance with eating. The MDS documented the resident was occasionally incontinent of bowel and bladder, had no oral or swallow problems, had no pressure sores and received diuretic medications (medication to remove excess body fluid). The hospital history and physical dated 12/6/13 recorded: the resident was hospitalized from 11/22/13 to 11/25/13 with pneumonia (a lung infection), had no bowel movement for several days and due to his/her poor intake and diarrhea became severely dehydrated prior to the family	F 281		

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bringing him/her to the hospital.

The December 2013 POS recorded the resident received the diuretic medications spirolactone and furosemide for a cardiac condition.

Review of the dietician's notes dated 1211/13 recorded the resident's diagnoses of dehydration, protein/calorie malnutrition (any disease promoting condition resulting from either an inadequate or excessive exposure to nutrients) and debility (weakness or lack of strength), noted the resident was below his/her ideal body weight of 146 pounds and required 1,380 milliliters of fluid a day. This same note recorded the resident drank soda, liked ice cream and refused health shakes.

The 12/11/13 temporary care plan recorded the resident was nutritionally at risk and received a regular diet, with magic cup, (a high caloric, high protein supplement) and house supplements (health shakes) at each meal.

The care plan lacked documentation to include the resident's risk for fluid loss (dehydration), use of diuretic medications, the resident liked soda and/or requirements for fluid intake noted by the dietician.

The undated Resident Care Planning policy recorded: Each resident had a Plan of Care (POC) that was current, individualized and consistent with the MDS, Triggers (areas flagged by the MDS assessment for review) and Resident Assessment Protocol (RAPS) (a narrative assessment of resident characteristics).

Review of the nurse's progress note dated 12/13/13 at 10:55 A.M. recorded the resident was

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F 281	Continued From page 14 transported to the hospital per family request. On 1/21/14 at 3:30 P.M. administrative licensed nursing staff acknowledged the resident admitted with a diagnoses of dehydration and pneumonia. He/she developed respiratory distress while at the facility and was sent to the emergency room. The facility failed to care plan risk factors and interventions to ensure adequate fluid intake for this cognitively impaired, dependent resident admitted with dehydration.	F 281		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This Requirement is not met as evidenced by: The facility identified a census of 54 residents. The sample included 19 residents. Based on observation, interview, and record review the facility failed to provide complete perineal care for 1 of 3 residents reviewed for incontinence. (#11) Findings included: - Resident #11's quarterly Minimum Data Set 3.0 Assessment dated 12-18-13 documented the resident's Brief Interview for Mental Status score was 14, which indicated the resident was	F 315		

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F 315	Continued From page 15	F 315		

cognitively intact. The resident required extensive assistance of staff for activities of daily living (ADLs) that included bed mobility, locomotion, toileting, and personal hygiene. The resident was incontinent of bowel and bladder.

The 10-1-13 Incontinence Care Area Assessment (CAA) triggered by the MDS but was not completed on the assessment.

The 11-26-13 care plan documented the resident had frequent incontinence at night and directed staff to initiate a scheduled toileting plan based upon his/her assessment. The care plan directed staff to assist the resident to the bathroom as needed and assist with perineal cleaning as needed. The care plan lacked individualized toileting interventions regarding the resident's incontinence and toileting needs.

The 9-19-13 Assessment for Bowel and Bladder retraining documented the resident was incontinent at night and the total score for the assessment was 14 which indicated the resident was a candidate for scheduled toileting.

The 3 day Voiding Pattern dated 12-26-13 and 1-3-14 documented staff stopped monitoring the resident's voiding pattern due to incontinence and directed staff to check and change the resident every 2 hours for incontinence. Staff also documented the resident continued to have loose stools.

The resident's record documented he/she had a urinary tract infection (UTI) on 10-7-13 and 1-12-14. On 11-11-13 the resident had a clostridium difficile (c-diff - a contagious bacteria characterized by foul smelling frequent bowel movements) infection.

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F 315	Continued From page 16 Observation on 1-16-14 at 1:09 P.M. revealed direct care staff R and Q in the resident's room. Direct care staff Q placed a gait belt around the resident and assisted the resident from his/her wheelchair into his/her recliner. Direct care staff R felt the incontinence pad in the resident's wheelchair and stated the pad was wet and they needed to change the resident's clothing and take him/her to the bathroom. They positioned the resident in the wheelchair and assisted the resident to the toilet. Direct care staff Q removed the resident's brief and revealed unformed bowel on the brief. At this time direct care staff Q stated the brief was wet from a watery bowel movement. Both staff assisted the resident to a standing position and the resident used the grab bar to stand while direct care staff R cleansed the resident's buttocks. Direct care staff R wiped between the resident's legs from front to back one time. He/she did not cleanse the front perineal area. Both staff assisted with putting a clean brief and pants on the resident and sat the resident down in his/her wheelchair on the wet incontinence pad. Both staff placed the resident in his/her recliner, removed the soiled clothing, removed their gloves and washed their hands. Neither staff removed the soiled incontinence pad on the resident's wheelchair until this writer reminded them and then direct care staff Q removed the pad. On 1-16-14 at 1:30 P.M. direct care staff Q stated the resident often said he/she was not wet or he/she did not need to use the bathroom, but would be wet or soiled with stool. On 1-16-14 at 3:02 P.M. direct care staff R stated he/she toileted the resident every 2 hours.	F 315		

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F 315	Continued From page 17 On 1-21-14 at 11:07 A.M. direct care staff P stated he/she toileted the resident frequently throughout the day. He/she stated the resident alerted staff at times if he/she needed to go to the bathroom and often had loose watery stools. He/she stated when he/she provided incontinence care he/she cleansed the entire area where the brief was. On 1-21-14 at 1:29 P.M. licensed nurse H stated staff checked the resident every 2 hours and the resident was able to state his/her toileting needs also, but when he/she needed to go to the bathroom, it had to be immediate, otherwise the resident was incontinent. He/she expected staff to cleanse the entire area where the brief was if the resident was incontinent of bowel and/or bladder. The undated facility provided Incontinence policy and procedure documented when the resident was incontinent of urine, bowel, or both, staff washed the area with soap, water, or periwash from the front to the back. The facility failed to thoroughly cleanse this resident's (with a history of UTIs and c-diff) entire perineal area following a watery loose bowel movement.	F 315		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441		

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F 441	Continued From page 18 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This Requirement is not met as evidenced by: The facility reported a census of 54 residents. Based on observation, record review, and interview the facility failed to track and trend infections. Findings included: - A review of the facility's Infection Control reports dated November 2013 to January 2014 for the skilled unit lacked information that tracked and trended the infections.	F 441		

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F 441	Continued From page 19 A report dated January 2014 revealed 8 residents were receiving antibiotics for Urinary Tract Infections (UTI) and Upper Respiratory Infections (URI) . The tracking record for that month had one name on it. The other 7 residents who received the antibiotics lacked trending. A report dated December 2013 revealed a map of the facility which was trended at the end of the month. Interview with administrative nursing staff E on 1/16/14 at 3:30 P.M. stated the company directed the staff to trend only the infections which met the criteria of McGeers definitions. Staff stated from now on he/she would trend the infections as they happened and would track all infections. Interview with administrative nursing staff D on 1/16/14 at 3:35 P.M. stated the infections were trended at the end of the month for Quality Assurance. The facility policy dated 12/15/12 documented the facility is to monitor and investigate the cause of infections, infectious trends, and implement corrective measures as needed. The facility failed to have a complete infection control program that trended infections.	F 441		